WORLD DEVELOPMENT

SPECIAL REPORT

AIDS: Time is Running Out

JUNE 1990

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UNDP photos by Ruth Massey

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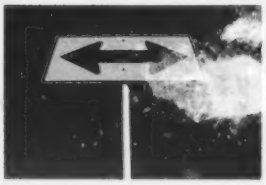

SPECIAL REPORT

AIDS: TIME IS RUNNING OUT

AIDS: Which Way to Go?
By Lloyd Garrison 4

The Future Face of AIDS.
By Elizabeth Reid 7

Brazil Takes Aim on AIDS. By Sid Kane 10

Rwanda: Running to Catch Up.
By I. Rajeswary 14

Thailand: From Secrecy to an All-out War on AIDS. By Lois Jensen 20

WOMEN

Weaving the Cloth of a Better Life.
Lao hilltribe women in Viet Nam now earn steady incomes. By Ruth Massey 24

ENVIRONMENT

Reviving Marine Resources. Philippine Fishermen and Scientists Join Forces.
By David Kinley 27

SPEAKING OUT

Stop Blaming Africa for AIDS.
By Dr. Augustin Hatar 30

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VOL.3, NO.4

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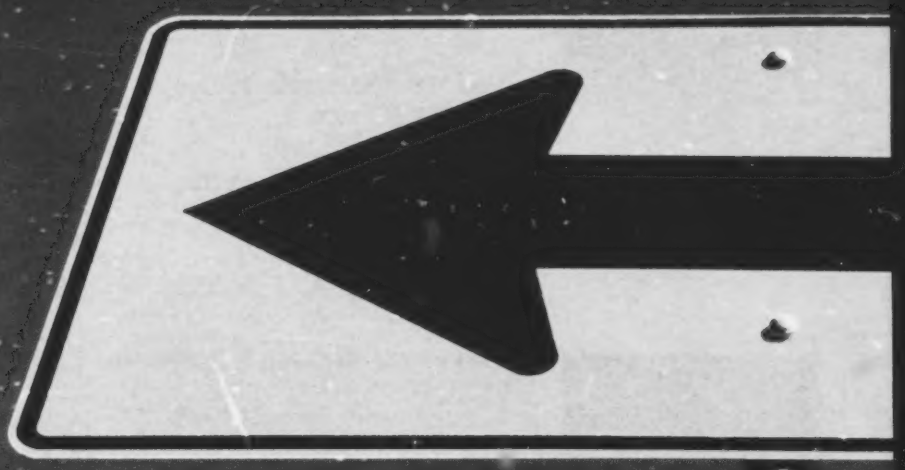
AIDS: Which



The world is caught up in a race against time.

By Lloyd Garrison

United Nations, New York — There is no longer any dispute about the threat posed by AIDS. Over 150 countries have reported cases of the disease. In parts of Central Africa, HIV — the deadly Human Immunodeficiency Virus which erodes the body's ability to fight off infection — has been detected in over 25 per cent of some communities.

It is rapidly becoming a family disease. As Elizabeth Reid reports in the lead article of this special report on AIDS, within a few years more women will be infected than men. In Africa alone, the number of children born to infected women is expected to reach one million by 1992.

But AIDS is no more of an African disease than it is an American one. Brazil's caseload is the largest in Latin America and fourth in the world, following the US, Uganda and Zaire. Nearly half of intravenous drug users tested in Thailand have turned up HIV positive. The virus knows no borders and transcends race, culture, creed, age, gender and sexual preference.

It is a disease so cunning that it lulls the bearer into thinking that he or she has no disease. Like a Trojan

The Image Bank/Gary Gay

Way to Go?

horse, the virus can lurk in the body for ten years and maybe longer — no one is quite sure — before attacking the immune system. During that time, a single individual may infect others, often those most dear.

Once the virus enters a society, it pursues a line of least resistance that runs directly through the most disadvantaged communities. "In the United States," observes Dr. Jonathan Mann, a leader in the global fight against AIDS, "it is increasingly becoming an inner city, minority problem. In parts of the Bronx the AIDS rates are similar to some of the hard hit areas of Africa."

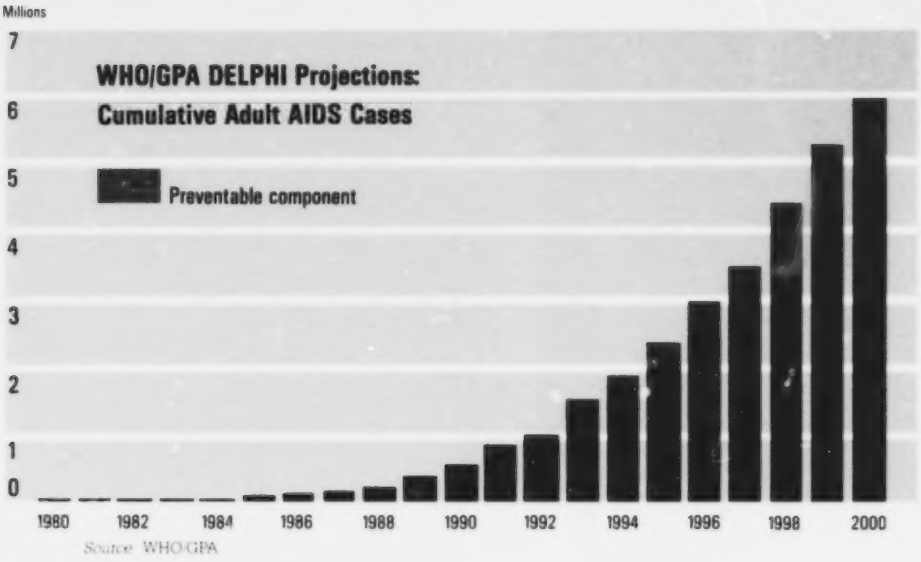
Throughout the world, it is the poor that suffer first — and most widely. Why? "Because," says Dr. Mann, "prostitution, which is a breeding ground for the virus, is a by-product of poverty. Because if you can't afford a condom, you can't protect yourself. Because poverty means unequal access to both treatment and prevention programmes. If you are poor and must rely on an overburdened public health system that fails to sterilize needles and dispenses unscreened blood, you are much more apt to contract the virus than those who can afford private health care. And if you are poor and cannot read, you are much less apt to get the message that prevention requires modifications in sexual behavior."

Dr. Mann, former Director of the World Health Organization's Global Programme on AIDS, sees few encouraging signs in the war on AIDS since the disease was first discovered a decade ago. "The number of new infections among male homosexuals is now declining," he reports. The shift is linked to an increase in condom use and a decrease in multiple sexual partners.

But with no cure for AIDS in sight, the developing world, where the virus tends to be most prevalent among heterosexuals, faces a formidable challenge. While most other deadly diseases mainly afflict the elderly, AIDS is snuffing out the lives of people in the prime of life.

The future cost of the epidemic among least developed nations, which can ill-afford any new burdens, is likely to be enormous. A glimpse of the potential of AIDS' fiscal impact is evident in a World Bank report that puts the average cost of treating an

READEX FICHE



More than half the AIDS cases in adults in the 1990s are expected to develop in persons already infected by 1988. Many of the projected AIDS cases that might arise from future HIV infections are considered to be preventable by global and regional HIV/AIDS prevention and control efforts carried out in conjunction with national programmes.

AIDS patient in Zaire at US$229 annually. Given Zaire's high rate of infection, the national health budget would have to increase by 58 per cent in three years just to maintain the same meager treatment levels now being dispensed. AIDS' financial impact on Zairean families can be devastating. A recent survey found that an average 25-day hospital stay for a child with AIDS costs the parents the equivalent of three months' wages. A child's traditional funeral observances, which are attended by relatives and friends over two to seven days, costs an average of 11 months income.

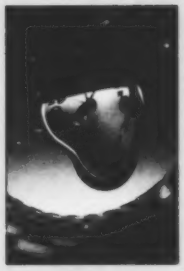
To help fill the huge gap in information about the future impact of AIDS, UNDP has launched an ambitious project to assess how the epidemic will affect developing countries in future years. The hope is that such knowledge will lead to new development strategies aimed at combating the most urgent problems arising from the spread of the virus.

UNDP remains the largest single multilateral supporter of the Global Programme on AIDS, whose main task is to support HIV/AIDS prevention and control projects and to collect data on the spread of the virus. WHO and UNDP have also forged an Alliance to Combat AIDS which joins WHO's bio-medical expertise on AIDS with the social and economic development experience of Resident Representatives in UNDP's 113 field offices throughout the developing world. The Alliance has proven particularly effective in providing funds on short notice to governments anxious to get their first AIDS programmes off the ground. On its own, UNDP has committed over $10 million in funds for HIV control projects in 28 nations.

The following special report includes up-to-date case studies on how three diverse nations — Brazil, Rwanda and Thailand — are fighting the epidemic. The one lesson that emerges from all three studies is that governments which delay responding to the first danger signals on AIDS are destined to pay a heavy price in both loss of life and loss of opportunities for future human development. Like the most calamitous of natural disasters — hurricanes, typhoons, earthquakes — AIDS has the potential to wipe out decades worth of development work.

What has also become clear is that AIDS is more than a medical problem, it is a societal problem that requires mobilizing every group within a nation to combat it. Thailand learned this the hard way. "We saw a problem in the gay community and we dealt with it," Thai immunologist Praphan Phanuphak told Associate Editor Lois Jensen. "Then we tackled the intravenous drug users. Now we are looking at female prostitutes, pregnant mothers and male heterosexuals. This is the wrong approach. Countries must jump several steps ahead of the actual situation — to protect those not yet infected."

"It is never too soon to start dealing with this disease," says Dr. Mann. "Looking to the 1990s," he adds, "the steps we take now may have an enormous impact on arresting the spread of the epidemic. It is not enough to just advise people to say no to behaviours which help spread aids. We have to develop the capacity to say no." ■



The Future Face of Aids

By Elizabeth Reid

United Nations, New York — The HIV epidemic is rapidly becoming a women's epidemic. One-third of all those thought to be infected — about 2,000,000 — are women. It is now estimated that the number of infected women may overtake the number of infected men by the mid-1990s.

Already in sub-Saharan Africa there are more women than men infected. Surveys in the Central African Republic, Equatorial Guinea and Gabon show nearly three times as many women infected than men. A Zairian study reports that among young adults aged 15 to 30 years, HIV infection is four times more common in women than in men. In many parts of Central America and the Caribbean, the male to female ratios of those contracting AIDS — the last stage of HIV infection — have dropped rapidly in the last three years from over 6:1 to well under 3:1. There has been a similar change in Thailand, as increasingly more women became infected.

It is also an epidemic of youth. At least half of all those infected are under the age of 25. Infection rates in some teenage groups is far higher than that for adults.

Perhaps most ominously for the future, the disease is now spreading to new-born children. Infection rates in pregnant women in high-incidence countries in Central and Eastern Africa range up to 25 per cent. It is estimated that infected women in sub-Saharan Africa have already given birth to 600,000 children. Of these, about 200,000 were infected during pregnancy.

These 600,000 children will have mothers that will sicken and die early in their lifetimes. UNICEF estimates that by the year 2000, ten per cent of children in ten high-incidence African countries will be without mothers as a result of this epidemic. Enough is known about the impact of protracted illness and death on households to be able to glimpse the impoverishment and suffering that will ensue for these children.

The HIV virus may be transmitted sexually through anal, vaginal or oral intercourse with an infected person. Sexual transmission can be prevented through the proper use of a good quality condom. But while young women in most parts of the world today are sexually active, condom use is uncommon.

Data on sexuality in developing countries indicate that initial sexual contact occurs before age 17 for half of the adolescent population. In Jamaica, Nigeria and Sierra Leone, more than four out of five single women aged 20 years are sexually experienced.

HIV transmission may also occur through the sharing of drug-using equipment with an infected individual. Protection can be achieved through not sharing needles, through the cleaning of shared needles or by not taking drugs by injection.

Fewer young women than young men are at risk of infection through drug injecting, since in almost all drug-using communities, men predominate. Young women are, however, at significant risk through unprotected sexual intercourse with past or present drug-users. It is virtually impossible to know whether another person is HIV infected, certainly during the long period of infection before symptoms appear.

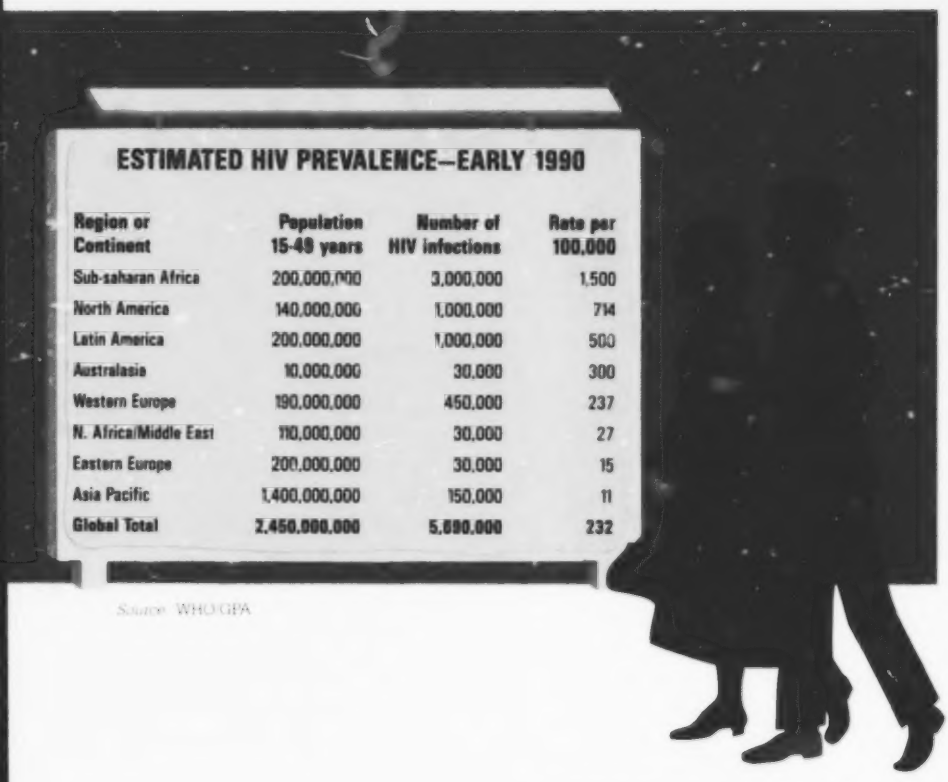
When it comes to regulating sexual behavior and intravenous drug use, only the individual can take the steps necessary to protect themselves from infection. The responsibility of governments is to make people aware of the epidemic and to ensure the means of preventing infection, including making condoms and sterile needles widely available, screening blood and ensuring that needles are sterilized in public health centres.

There are many factors affecting the lives of young women which make them vulnerable to HIV infection. The extent

ESTIMATED HIV PREVALENCE—EARLY 1990

Region or Continent	Population 15-49 years	Number of HIV infections	Rate per 100,000
Sub-saharan Africa	200,000,000	3,000,000	1,500
North America	140,000,000	1,000,000	714
Latin America	200,000,000	1,000,000	500
Australasia	10,000,000	30,000	300
Western Europe	190,000,000	450,000	237
N. Africa/Middle East	110,000,000	30,000	27
Eastern Europe	200,000,000	30,000	15
Asia Pacific	1,400,000,000	150,000	11
Global Total	2,450,000,000	5,690,000	232

Source: WHO/GPA



of sexual assault against young women has been largely hidden and widely denied. Rape and incest are gross violations of young women and, if the attacker is infected, clearly place them at risk of HIV infection. Despite the paucity of data, there is evidence that sexual assault against women is rising in some parts of the world, particularly in the Caribbean.

The HIV epidemic carries within it the seeds of violence. There are increasing reports of the rape of young women by older men in high-incidence countries. This is clearly associated with the belief that the younger the woman, the more she is likely to be free from HIV infection. The raped young woman, however, is at high risk of infection, particularly since reports indicate that the attackers are usually either sexually promiscuous men who do not want to change their behavior or, increasingly, may be men who have lost their wives, possibly to AIDS, who are fearful of taking another wife.

The group of young women and men most vulnerable to HIV infection are those who are homeless or living in poverty. UNICEF estimates that over 40 million young people in the world are living on the streets. Many of those have left home because of sexual abuse or poverty. Studies from Latin America, Africa and North America show alarming rates of infection in this group.

With as many as seven million homeless children living on the streets in Brazil, authorities believe that 140,000 children may already be infected. Child prostitution is common, involving girls of nine or ten who often work just for food or shelter.

In New York City, one 1988 study of more than 1,100 young men and women aged 16 to 21 living on the street, revealed that over seven per cent were HIV positive. Almost none of them injected drugs; transmission occurred sexually. In Khartoum, a 1988 study of street boys aged six to 14 showed seven per cent of them to be infected; how the virus was transmitted was not determined.

The options for women, young girls

Illustration by J. Keeler

and children living in poverty are few, and none rival prostitution as an economic survival strategy. Nowadays, however, to engage in prostitution in many parts of the world is a virtual death sentence for the woman and the children she loves and supports. Levels of HIV infection among women working as prostitutes in some Central and Eastern African towns and cities are as high as 80 or 90 per cent.

However, there is evidence of a decrease in new infections among these women as they organize to protect themselves and to educate and protect their clients. Prostitutes' collectives and similar organizations now exist in countries as diverse as Australia, Brazil, Kenya and Thailand. A growing number of non-governmental organizations, especially in Latin America, are assisting prostitutes with client education.

Diagnosis of HIV infection in a young woman means not only the possibility of illness and death but also that choices about sexuality, motherhood, marriage, education and work become fraught with fear and pain. Disclosure of one's infection has a high price. Infection too often means social isolation, loneliness and discrimination. It also brings fear. The fear of losing one's job, housing and medical care. The fear of losing family, friends and partner. Fear for the future of one's children.

For a young woman, a diagnosis of HIV infection brings with it an anguished choice: to forego children or to risk giving birth to an infected baby. For young women in cultures where their social identity and acceptability is determined by their fertility, there may not even be this choice. The sexual expression of love may become difficult either for the infected woman or for her partner. Relationships become difficult to enter into and to maintain. Whether or not to tell young children becomes an infected mother's central concern.

This is a sad picture and reflects reality, but not in its totality. An infected young man or woman has years, maybe a decade or more, of healthy life ahead after infection. We need to ensure that these infected young people remain an integral part of the community's social and economic life.

We have knowingly lived with this epidemic for a decade now. We know that, ultimately, responsibility for preventing the spread of the virus through sexual or drug-using behaviour lies with the individual. Family, friends and governments can only provide an environment which may assist individuals to change behaviour. They cannot change it for them.

The challenge now is to apply this understanding to the young women and men of our societies. We must acknowledge their vulnerability to infection — not an easy task for parents, church and community leaders or governments to face up to. We must ensure that they themselves acknowledge their vulnerability to infection — perhaps an even more difficult task. Most challenging of all, once this awareness of vulnerability is created, will be to impart the self-confidence and skills required to change behaviour. ■

Elizabeth Reid, *a specialist on the global impact of the HIV epidemic, is Director of UNDP's Women in Development Division. This article was adapted from an essay prepared for International Development, issue no. 1, 1990.*

Brazil Takes Aim on AIDS

By Sid Kane

A mural in downtown São Paulo paints a chilling picture of AIDS.

UNDP photos by Sid Kane

Dr. Maria Eugênia Lemos Fernandes displays a T-shirt given to high school students.

BRAZIL

São Paulo, Brazil — A flyer being handed out at the airport here reads, "Don't let AIDS become your last travelling companion." A T-shirt distributed to high school students says, "Condoms, my cry of freedom." A large mural in downtown São Paulo delivers a more graphic message: an angel stricken with AIDS is shown falling to earth. A child beneath it proclaims, "Even angels can get AIDS."

With no cure in sight, few resources and a shortage of trained medical personnel and hospital beds, Brazil is waging a war of words against AIDS, hoping to stem its transmission and save lives. Over 10,000 Brazilians have developed the disease since the first case was diagnosed in 1982. Most of these have died. According to estimates of the World Health Organization (WHO), as many as 200,000 more could be infected with HIV, the Human Immunodeficiency Virus which causes AIDS and resides in the human body for as long as ten years before revealing its deadly presence.

The health challenge posed to this huge developing country, which occupies nearly half the area of South America, is staggering. Brazil's reported caseload is the largest in the region and fourth in the world, following the United States, Uganda and Zaire.

"Fighting AIDS in Brazil is like taking water from the ocean a spoonful at a time," says Dr. Maria Eugênia Lemos Fernandes, Director of Health Education at the Reference and Training Centre for AIDS in São Paulo. "The disease will become a real tragedy here because it is compounding the many social, economic and health problems that already exist, and for which we've never had any solutions."

One of these seemingly unsolved problems involves an estimated seven million homeless street children. Many are drawn into prostitution and drug-use. A related problem is Brazil's 22 per cent illiteracy rate. Being able to read, health officials say, has become a matter of life and death as information on AIDS is spread via print media campaigns, especially in remote rural areas.

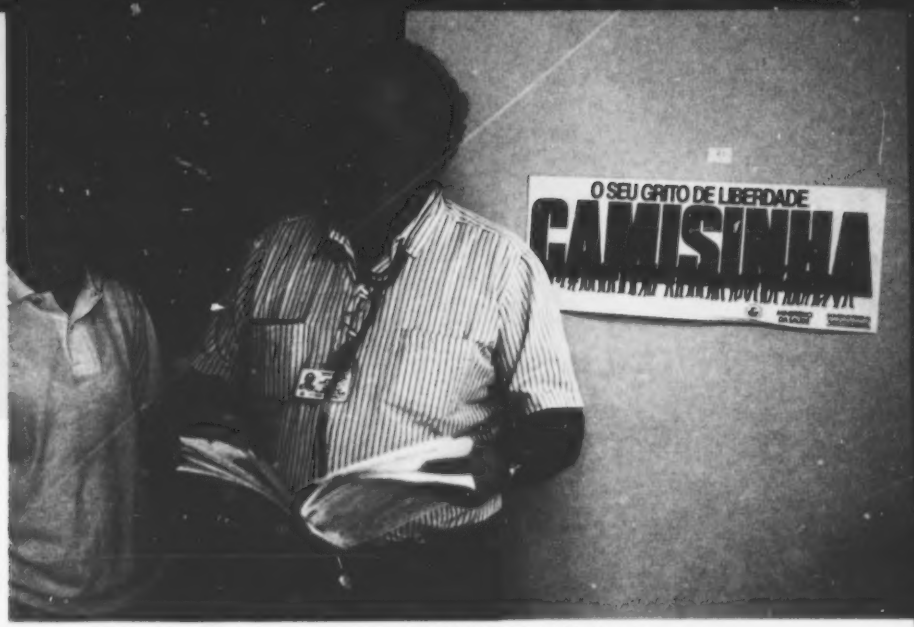
"There are still people in Brazil who don't know how AIDS is contracted. Often they are illiterate," says Dr. Arletty Pinel, Chief of Promotion and Education for the Health Ministry's Division of Sexually Transmitted Diseases and AIDS. "The disease is spreading faster than people think in cities like São Paulo and Rio de Janeiro," she reports. "We want people to know that they can gain control over AIDS if they get appropriate information and adopt the right attitudes."

But getting people to adopt the right attitudes in Brazil, a country of immense poverty, is no easy task. "Condoms sell for US$1.50 a three-pack," says Dr. Pinel. "If a person earns $50 a month, and is helping to support his family, how many do you think he'll buy?"

Brazil's sheer size and its cultural and social diversity have made the epidemic even more difficult to control. "Brazil is many countries within a country, so there can be no singular AIDS strategy," says Eduardo Gutierrez, Resident Representative for the United Nations Development Programme (UNDP) in Brazil. "When dealing with AIDS in high-income areas of São Paulo, people want the latest clinical treatment and advice. In the poorer regions of the Amazon, the demand is greater for basic education and hygiene."

Improving its ability to track and analyze the progression of AIDS is a priority in Brazil, and UNDP, through a cost-sharing arrangement with the government, is providing computer equipment and expertise. Along with computerizing its AIDS data base, UNDP is helping the Health Ministry create an information network that will link it with international health organizations studying AIDS worldwide. UNDP has also provided health specialists, epidemiologists and laboratory diagnosticians who are assisting the government in mapping a new AIDS strategy.

As part of Brazil's AIDS education programme, seminars are being conducted for health professionals, including doctors, educators and government staff.



Dr. Paulo Augusto Ayroea Galvão at the out-patient clinic for AIDS in Emílio Ribas Hospital.

UNDP photos by Sid Kane

Media campaigns focusing on AIDS, including television and radio spots, pamphlet and poster distribution, are already underway.

Groups thought to be at potential risk are being counselled about AIDS — such as Indians who live in the northern mining towns of Pará and Rondônia states. An influx of gold miners in recent years has brought prostitution, and with it, sexually transmitted diseases to these areas. "We're also targeting high-risk groups in big cities for more direct action," Dr. Pinel says. "We're hiring and training 'peers' to go out late at night and talk with intravenous drug users and prostitutes."

Caring for Brazilians with the disease is as great a challenge as prevention. In São Paulo, whose 16 million people make it the third largest city in the world, there are only 160 beds for AIDS patients in public hospitals. Three years ago, an AIDS victim who could not find a hospital bed died outside a medical facility in front of a crowd of television cameras. The incident helped to make health care for AIDS patients a national issue.

"I'd like to see 1,000 more hospital beds in São Paulo for AIDS victims," says Dr. Paulo Augusto Ayroea Galvão, Director of the Emílio Ribas Hospital, the largest in the country for infectious diseases. "We are in the eye of a storm now in Brazil. We are fighting AIDS, meningitis, yellow fever, malaria and more. But the greatest endemic disease in our country today is ignorance — on the part of some medical professionals who still refuse to treat AIDS patients, and on the part of people who've been trained to use condoms and don't."

Devastating as the disease is, the stigma often associated with AIDS has made its consequences all the more unbearable. Patients have been denied hospital care when it was disclosed that they had AIDS. Despite a government recommendation that advises against screening job applicants for HIV, some employers still do so. And although social discrimination against AIDS victims has begun to wane during recent years — as the disease is no longer confined to intravenous drug users and homosexuals — by no means has it disappeared. After a photograph of an AIDS victim was published in a local newspaper, his house was stoned.

"My parents don't tell their neighbours that I have AIDS," says a young architect who contracted the disease while living in North America. "They say that I'm suffering from cancer. They have to in order to survive socially."

To recover from a recent bout with the disease, which left him weak and debilitated, the architect has come to the outpatient clinic at the Emílio Ribas Hospital. For several hours each morning, he has been receiving a serum intravenously that is rich in vitamins. The treatment is replenishing the vital nutrients in his body that were destroyed during the attack, and has helped to restore his strength. Several other AIDS patients are nearby, receiving the same serum. In the clinic's hallways, posters warn about the dangers of the disease, and the wisdom of using condoms.

When the first AIDS cases were reported in Brazil, they were mostly confined to wealthy individuals who became infected while travelling abroad, and were concentrated among male homosexuals. Today, ten per cent of all AIDS patients in Brazil acquired the disease heterosexually, according to government figures. In 1984, infected males outnumbered women with AIDS by 120-to-1. By last year the ratio had dropped to 8-to-1.

In 1987, the government passed a law to ensure that all blood banks screen for the presence of the HIV virus. Since then, the number of new cases caused by contaminated blood transfusions dropped from 7.3 per cent annually to 3.6 per cent. "The blood supplies in Brazil's large cities are virtually 100 per cent clean now," says Dr. Pedro Chequer, Chief of the Epidemiological Unit for Brazil's Division of Sexually Transmitted Diseases and AIDS. "But we still have problems of blood safety in some rural

Dr. Lair Guerra de Macedo Rodrigues, Director of Brazil's National Division of Sexually Transmitted Diseases and AIDS.

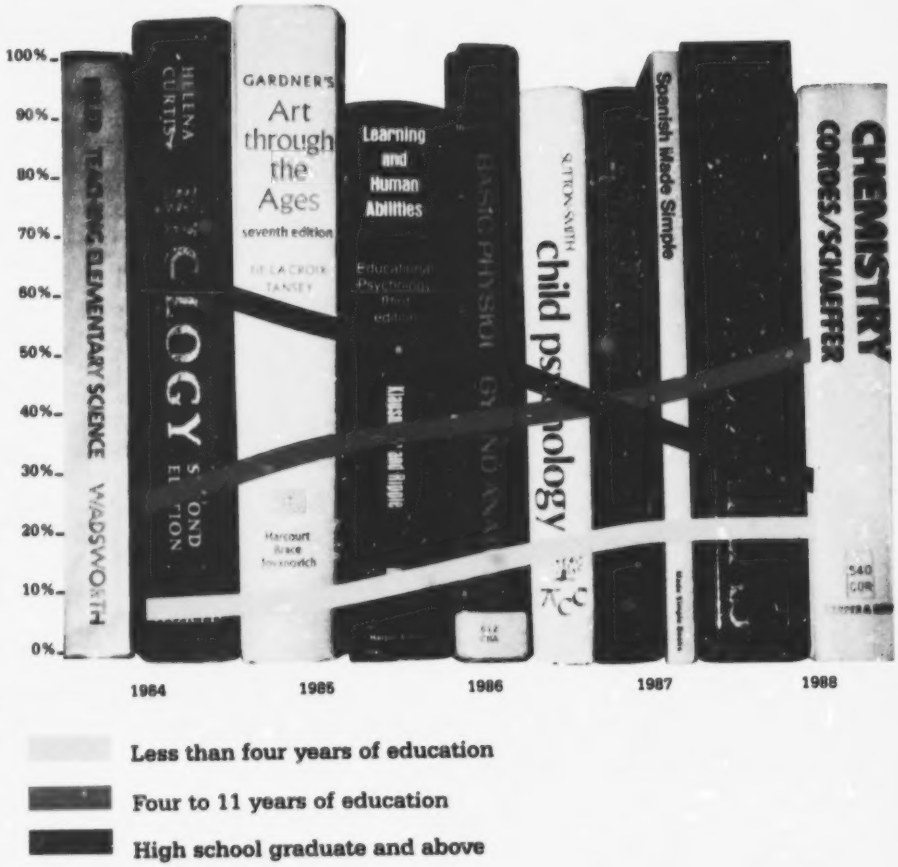
areas, where the law is hard to enforce."

While getting the word out about AIDS is an important part of the government's strategy, getting people to listen is not easy. "There's never been a tradition of preventive medicine in Brazil, which is fundamental to fighting AIDS," says Dr. Fernandes. "People here don't pay attention until they become sick. This makes the AIDS epidemic all the more dangerous."

A long history of disease and poor health conditions in Brazil has lessened concern about AIDS on the part of many Brazilians, health officials say, especially among the poor. The country has a high infant mortality rate of 85 per 1,000 live births, and one-third the population of Rondônia suffers from malaria. "There are so many other health and social problems that people have become accustomed to living with disease," says Mr. Gutierrez, the UNDP Resident Representative.

Indeed, perhaps the biggest hurdle standing in the way of efforts to curtail the epidemic is public indifference to AIDS. "People in Brazil haven't changed their casual style of sex," says the stricken young architect. "Any media campaign has to be hard-hitting. It's worth shocking people. Brazilians have to realize they could die." ■

Brazil—Educational Level of AIDS Cases by Year of Diagnosis



Source Ministry of Health/Brazil

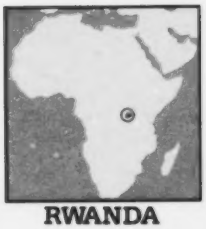
Rwanda: Running to Catch Up

The government is bearing down hard in the race against AIDS

By I. Rajeswary

UNDP photos by I. Rajeswary

Dr. Didace Nzaramba, Director of Rwanda's National AIDS Programme.



RWANDA

Nurse Dina Martinez.

The Nyamirambo Health Centre serves the low-income community in Bilyogo.

Kigali, Rwanda — Jean Baptiste, now 37, an assistant accountant with a commercial bank, had a lifestyle which was the envy of his friends. He wore well-cut clothes. He could afford fine restaurants and had money to pay the school fees for his four older children while his wife, Maria, stayed home with their fifth child in a village near here. But two years ago, things began to fall apart.

In 1988, his youngest developed tuberculosis and died of complications at age three. He had AIDS, which attacks the immune system that protects the body from life-threatening diseases. Doctors asked Jean Baptiste, which is not his real name, to take a blood test. It confirmed their suspicions that he too had contracted the human immunodeficiency virus (HIV). He thinks that he may have caught it from a woman he was seeing in the city. He then infected his wife who transmitted it to their youngest child at birth.

Initially, Jean Baptiste refused to believe he had the virus. He was, after all, a healthy man. But last September, the 37-year old accountant was hospitalized for more than a month because the wounds he suffered in a fall simply would not heal. Five months later he was back in hospital with a chest infection. He then developed sores on his head. In April, he was hospitalized for the third time with respiratory problems. Now, too weak to sit up, he languishes in his bed throughout an hour-long interview, his voice no louder than a throaty whisper.

"I get these headaches and they won't go away. The doctors have done tests but I don't know the results yet. I can't stand the pain," he says. He rubs his hand over his badly-scarred scalp and closes his eyes. "I wish they would give me stronger painkillers. I prefer injections," he says. Many patients prefer injections for almost any malady, believing them to be more powerful than pills. While the Kigali hospital's needles are sterilized, many used elsewhere are not, and this increases the chance of spreading the HIV.

"I want to get back to work," says Jean Baptiste, not realizing that he may have only a few months more to live. His wife, Maria, 33, who visits him daily, watches him intently. They have been married for 17 years. She, too, is infected.

It is not that Jean Baptiste had never heard of the deadly disease. The first ten cases in Rwanda were detected in 1983. By March 1986, the government had started an intensive campaign informing people about AIDS. Jean Baptiste, like many others, declined to be

A new wing is being added to the Centre Hospitalier de Kigali to cope with mounting patient load.

UNDP photos by I. Rajeswary

tested because he believed that only "bad" people became infected.

Despite all the government's efforts, the rapid spread of AIDS has already imposed a heavy burden on Rwanda, which tourist brochures describe as the "Land of a Thousand Hills." It is a small land-locked country with a population of more than seven million and a GNP per capita of only $270. The average family has eight children and lives on less than half a hectare of land. It is the most densely populated country in Africa, with an annual population growth rate of 3.7 per cent. While nine out of ten families live off agriculture, land is so scarce that even the patch between the home and the road is cultivated with millet, beans or maize.

The country's first ten HIV cases, says Dr. Didace Nzaramba, Director of Rwanda's National AIDS Programme, were traced to prostitutes, those with multiple sexual partners or those who received the virus from infected blood or unsterilized needles. "There were no homosexuals or drug addicts," he says.

In March 1986, Rwanda's Ministry of Health (MINISANTE) created a National Commission for AIDS. It also began to fashion an intensive campaign, in collaboration with the Rwandan Red Cross, to educate people on the dangers of the disease. Since there is no television yet in Rwanda, the government had to rely heavily on radio, newspapers, posters and pamphlets. It was a daunting task, as 74 per cent of the country's women and 52 per cent of the men are estimated to be illiterate. A Rwandan journalist, Augustin Hatar wrote a play, *Pick Up Your Shield, We Are Being Attacked*, advising people to be prudent about sex. It is still being widely performed in villages and market places in *kinyarwanda*, the national language.

As it began dispensing information on AIDS, the government also mounted a survey of urban and rural areas to determine the prevalence of infectious diseases transmitted by blood such as Hepatitis-B, malaria and syphilis, including AIDS. A total of 2,800 blood samples were taken. The findings showed the HIV to be present in 1.7 per cent of Rwandans in rural areas and 18 per cent in urban areas. Those infected came from all age groups, and men and women were equally represented. "We published the results and distributed them to all ministries and embassies," Dr. Nzaramba says.

That was in 1986. Today, some authorities on AIDS put the prevalence of the virus at 27 per cent in urban areas and over three per cent in the rural areas. In 1988, to determine how its education campaign was being perceived, the government conducted another survey and found that 90 per cent of the population had heard about AIDS but most thought it did not really concern them. Although some Rwandans were volunteering to be tested, says Dr. Nzaramba, AIDS is still thought to be mainly the illness of prostitutes and migrant workers. Moreover, many people thought they could get the virus from shaking hands, mosquito bites, using the same cooking utensils of those infected and even breathing the same air. "We had to set right such notions," says Dr. Nzaramba.

In Kigali these days, setting people right on AIDS takes place from 9:00 am to 5:00 pm in a government information centre with a sign which reads "Let's Talk AIDS." Ndibeshye Théoneste, National Co-ordinator for AIDS Education, says anyone can walk into the centre, ask to see a counsellor, collect AIDS literature and obtain free condoms. Although the government, along with the United Nations Population Fund, is actively promoting condoms, their use is alien to the culture. Outside the centre, condoms are also expensive — 50 cents each in the market and a dollar in pharmacies.

Authorities are discovering that they must exercise care in telling people

Dr. Aloys Bigirinkana, Director of the Centre Hospitalier de Kigali, Rwanda's biggest hospital.

that they are HIV positive and should be accompanied by careful counselling. Professor B. T. Nasah, Director of the WHO Regional Centre for Research and Training, recalls that in early April, a man who volunteered for the HIV antibody test and was found to be positive "went home and slashed his wife because he thought she gave him the virus. The man is now in prison while his wife is in hospital."

"When men are told they are HIV positive," says Dr. Maria Neira, a UN volunteer, who is a physician for the 2,000 local and expatriate community of the United Nations system in Kigali, "some get very angry and deliberately sleep with as many women as they can to contaminate them."

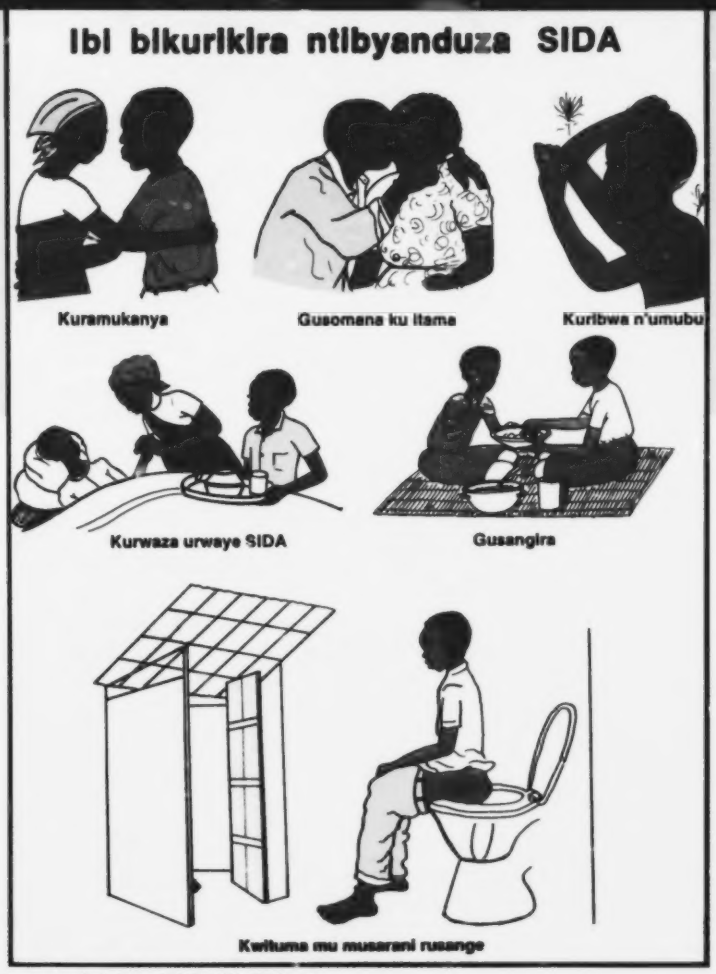
According to Dr. Nzaramba, while most Rwandans infected with AIDS are looked after by their families, there are cases in which some patients are isolated by their families and not allowed to mingle with relatives, let alone the community. One woman committed suicide when she found out that she had contracted the virus from her husband. At Kigali's biggest hospital, the Centre Hospitalier de Kigali, there have been instances when family members abandoned their loved ones because they couldn't stand the pain of watching them slowly waste away.

Unlike many other African countries with their many ethnic groups, Rwanda has succeeded in placing most orphans with foster families within Kigali. "But it is becoming harder and harder," he says. He blames foreign films with their emphasis on violence and sex for a liberalization of sexual practices among young Rwandans. **—I.R**

Finding foster families is getting harder and harder

More than 45 per cent of Rwanda's population is Roman Catholic. CARITAS, a Catholic relief service, was set up to help the poor. But increasingly those seeking its help are women whose husbands are dying of AIDS or women who have contracted the virus themselves and want to place their children in CARITAS' care. Up to June last year, four men and 212 women and children had come to the centre for help for problems related to AIDS. By April this year, the number had risen to 141 adults and 485 children, many of them orphans. So far, says Father Michel Descombes, the organization's secretary-general, CARITAS

Father Michel Descombes of CARITAS.



Rwandan Red Cross, PNLS, UNICEF, Kigali

This poster in *kinyarwanda* tackles myths, showing ways AIDS is not spread.

is fortunate in that everyone speaks *kinyarwanda*, thus eliminating the need to translate AIDS materials in different languages, says Ofori Akyea, a Ghanaian, who is UNICEF's representative in Kigali. UNICEF's AIDS prevention programme is directed at school-age children and more than a million unemployed youths up to the age of 25.

The government, with help from UNICEF, is refining an AIDS prevention curriculum for schools. In December 1988, the government published booklets on AIDS and trained 3,800 teachers so that they can inform school children about the disease. "Eventually, we hope to include a course on the disease in both primary and secondary schools," says Dr. Nzaramba.

Such education is considered to be the most effective long-term measure in preventing the spread of the disease. "Once people understand the gravity of the sickness, we can prevent it," Dr. Nzaramba says. "But what is even more important is the need for people to change their sexual practices — not to have multiple partners. This is our hardest task."

There are clear signs that the message is getting through. "Four years ago, we could not really talk about AIDS here, but now it is out in the open and it is largely due to the government's initiative," says UNDP Resident Representative in Kigali, Edouard Wattez. He also credits international donors for their swift response to the government's requests for assistance.

Rwanda's poor seem to suffer from AIDS most. Nurse Dina Martinez, who runs the Nyamirambo Health Centre in Bilyogo, a low-income community on the outskirts of Kigali, says in 1986, 34 per cent of the women tested in Bilyogo were found to be HIV positive. Most of them were infected by husbands who reside in the city on weekdays and return home to be with their families on weekends. "Many of the women are resigned to their fate," she says. Together with social workers at the centre, Ms. Martinez counsels persons with AIDS and advises relatives how to look after them.

The Centre Hospitalier de Kigali is the country's largest hospital. It has 500 beds but its occupancy rate is 180 per cent. "Sometimes patients have to share beds," says Dr. Aloys Bigirankana, the Centre's director.

Half of the patients in the hospital's Internal Medicine Unit are HIV positive, says Dr. Henri Taelman, an Associate Professor in tropical medicine. The ward has 120 beds occupied by 200 patients.

Visiting hours are 4:30 pm to 9:00 pm in the evening. The crowded male unit is filled with occasional groans and the soft shuffling of feet as some patients with walking sticks are helped by relatives as they attempt to exercise. Young children dart about the aisles. Adults cluster around the bedsides of their loved ones, speaking in low voices.

Those who share beds sleep facing away from each other. In a small room at the entrance of the ward, the clatter of enamel pans and dishes continues as nurses sterilize needles in a chipped metal basin placed over a powerful Bunsen burner. The air reeks of medicine and decay.

In the smaller women's ward, silence prevails. The younger of the women turn their faces away when visitors enter. Older women look on indif-

A scene from the play *Pick Up Your Shield, We Are Being Attacked*, depicts friends deserting an AIDS patient. The play, which is performed free in villages and rural areas, has drawn thousands of people.

ferently. Those with sores on their bodies are without bedclothes that might cause friction when they move. Some mothers lie in bed with their children, stroking them. The children, too, are silent.

The Paediatrics Unit has 70 beds. Dr. Philippe Lepage, who heads the Unit, says that while malaria is still the first cause of death in the hospital, in the last ten years, he has seen a marked increase of children who are HIV-positive. As in other countries with the AIDS problem, says Dr. Lepage, in Rwanda, one out of three infected mothers gives birth to a HIV-positive child.

During a tour of the hospital, Dr. Bigirankana talks of expansion plans. A new wing is under construction to accommodate 120 new beds. A hospital training school is vacating its premises, giving him an additional 120 beds. But back in his small Director's office, seated behind a plain steel desk, his voice drops to a tired whisper. "It is depressing to see so many infected people," he says. "I am not optimistic — at least not for the infected persons in the urban areas. But I hope we can prevent the disease from spreading among the rural population. It's a race against time." ■

Answering a Call for Help

In February 1987, the Rwandan government, in co-operation with WHO's Global Programme on AIDS, drew up a five year plan for the prevention and control of the disease. A total of US$9.3 million has been pledged mainly by Belgium, Canada, Denmark, the European Economic Community, France, the Federal Republic of Germany, The Netherlands, the United States, UNICEF, the United Nations Development Programme (UNDP) and WHO.

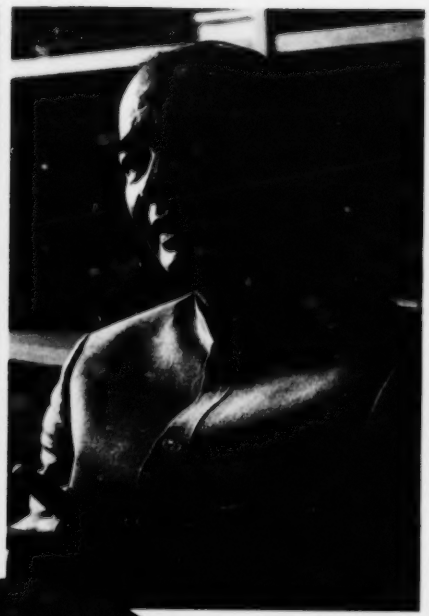
The United Nations Capital Development Fund (UNCDF), which is administered by UNDP, is investing $854,560 over three years to help strengthen Rwanda's National AIDS Programme. UNCDF programme officer Lucien Jean Magnin says the organization will also bear the cost of building and equiping a modern blood transfusion centre.

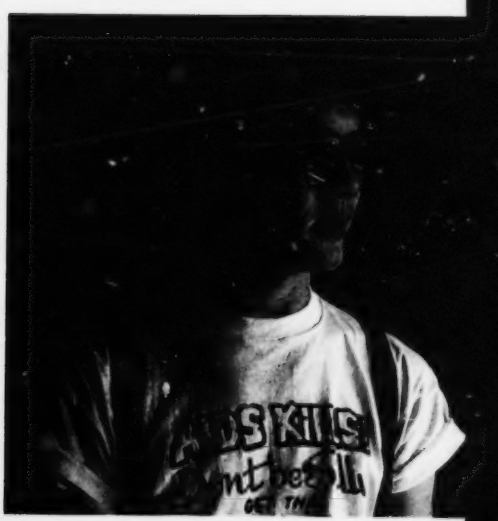
UNCDF Programme Officer Lucien Jean Magnin.

UNDP photos by I. Rajeswary

Thailand: From Secrecy to an All-out War on AIDS

By Lois Jensen





The war on AIDS in Thailand is unique because of the many non-profit groups and individuals who are working alongside the government. Those on the front line include *(left to right)* immunologist Praphan Phanuphak, Mechai Viravaidya, head of the Population and Community Development Association, and artist Natee Teerarojjanapongs.

Anthropologist Werasit Sittitrai and Red Cross volunteers are surveying sexual behaviour in a rural community outside Bangkok.

UNDP photos by Lois Jensen

THAILAND

Bangkok, Thailand — Four years ago, while doing field research in dirt-poor northern Thai communities, anthropologist Werasit Sittitrai was struck by the absence of young women. When pressed, village elders admitted that the girls had left "to sell sex," earning more money than their families ever dreamed of.

From the massage parlours of Pattaya in the south to the brothels of Chiang Mai in the north, prostitution, though illegal, is tolerated and widespread in Thailand. Of particular concern today is the fact that hundreds of thousands of commercial sex workers, particularly poor and ill-educated females, are the newest high-risk group for AIDS.

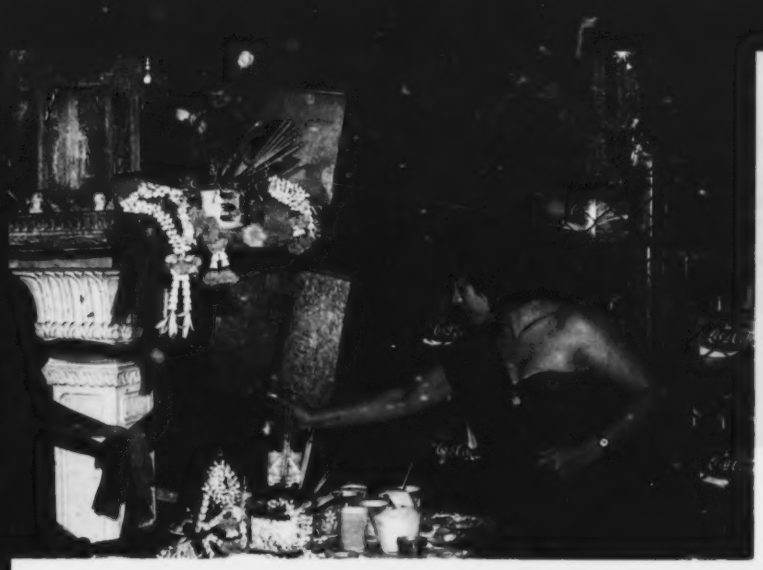
Today Werasit Sittitrai teaches at Chulalongkorn University. In his spare time, he works with a coalition of volunteers against AIDS, writing television spots, designing posters and organizing surveys for the Thai Red Cross Society.

For years, AIDS was considered an imported disease and not a real threat. The first identified case — a Thai homosexual who had been living in the United States — was reported in 1984. In 1988, the problem was rudely brought home when sample surveys in Bangkok showed that HIV infections were racing through groups of intravenous drug users. Until that time, AIDS had been officially played down out of concern for its potentially negative impact on tourism, Thailand's biggest source of foreign exchange.

The shift from secrecy about AIDS to an all-out war against it has been phenomenal. "Few countries in the world have mobilized themselves so quickly," says Dragan Stern, representative of the World Health Organization (WHO) to Thailand.

The reaction came none too soon. The HIV epidemic in Thailand is still at a relatively early stage (there were only 37 full-blown AIDS cases reported as of March 1990). But a combination of factors, including one of the highest per capita rates of intravenous drug use in Asia and a lively sex industry, makes it a potential time-bomb. More than three-quarters of the known infected persons in Thailand are intravenous drug users scattered throughout every province, shooting heroin and often sharing infected needles. But with increasing sexual transmission, there is mounting evidence that the virus is creeping into the general population as well.

Today, according to the latest government figures, there are 15,000 reported cases of persons infected with the HIV virus in Thailand. The number of actual carriers is projected at around 50,000. Population expert Mechai Viravaidya says that this is just the tip of the iceberg, and that the number could



A bar worker in the Patpong area of Bangkok makes an offering at a Buddhist altar outside the club.

easily be ten times as high.

What alarms health workers most is the rate at which AIDS has spread. From February 1987 to September 1988, HIV infections shot up from four per cent to 42 per cent among intravenous drug users. Infections among female sex workers, particularly in poorer northern regions, has been a cause for deep concern. One study in the northern city of Chiang Mai turned up an overall positive rate of 43 per cent among female prostitutes, soaring to 72 per cent among the lowest-paid women.

In June 1988, a national programme for the prevention and control of AIDS was launched under the general policy framework of WHO's Global Programme on AIDS. Now in its third year, the Thai effort has attracted more than US$10.8 million from the government and 11 international sources. After the Government of Thailand, the United Nations Development Programme (UNDP) is the second largest donor, contributing $1.9 million to date.

Working through a sophisticated Thai public health system, this ambitious anti-AIDS campaign has already made an impact. Country-wide surveys are undertaken twice a year. A vigorous programme of voluntary testing has reached more than three million people, according to one Ministry of Health official. All of the country's 200,000 health workers will have completed specialized training on AIDS by the end of this year. And AIDS information is now part of all secondary school curricula. An intensive awareness campaign through radio, television, posters, exhibits, publications and other mass media, continues to spread the word on what AIDS is and how to prevent it.

There are signs that the message is getting through. Contrary to expectations, the rate of infection among drug users and homosexuals has reached a plateau. Over the course of last year, the incidence of sexually transmitted diseases decreased by seven per cent, presumably the result of increased condom use.

The permissive, non-judgmental attitude which is characteristic of the Thais is playing a role in fighting the disease. In general, health workers are trusted and have ready access to addicts and commercial sex workers. Through all of the city's 87 drug rehabilitation centres, bleach is provided to addicts to sterilize needles, and an information campaign is reaching the poorest of the poor in Bangkok's slums.

More than 19 million condoms have been distributed free by the Ministry of Health. Its mobile teams, which will eventually travel to all parts of the country, are now visiting Bangkok's nightclubs and bars with graphic audio-visual presentations on the deadly disease. Even Her Royal Highness Princess Chulabhorn, daughter of Thailand's constitutional monarch, has personally taken on the cause of AIDS.

What stands out most visibly is the energy and enthusiasm of Thailand's non-governmental organizations (NGOs), which are slated to receive increasing support from the national programme in years ahead. Sompong Patvichaiporn, director of the Planned Parenthood Association of Thailand, is leading the way in teaching prison officials about AIDS. Natee Teerarojjanapongs and his Purple String Dancers are performing skits about AIDS on television and in Bangkok's gay bars. A feminist group called Empower, led by Chantawipa Apisuk, is helping to raise awareness about AIDS among the 5,000 female bar workers of Patpong, Bangkok's most frequented red-light district.

Among the most militant of the NGO leaders is Mechai Viravaidya, head of

Mobile teams from the Ministry of Health are making the rounds of Bangkok's night spots with slide shows on AIDS, while also offering voluntary testing.

UNDP photos by Lois Jensen

the Population and Community Development Association, who is widely credited as being the driving force behind the success of family planning in Thailand. Mr. Mechai, whose name has become slang in Thai for condom, is bringing the same missionary-like zeal and off-beat advertising sense to the battle against AIDS that he used in fighting the population explosion.

Mr. Mechai's current arsenal includes desk calendars and leaflets illustrating the more grisly manifestations of AIDS, as well as an imaginative variety of key chains. "In case of emergency, break the glass," is the message on one key chain. It contains a condom enclosed in clear plastic. He has also marshalled an army of Avon ladies, who distribute AIDS information along with lipstick and face creams, and taxi drivers, who hand out condoms and safety tips while playing an AIDS information tape to their captive audiences.

While acknowledging the efforts being made by the government, Mr. Mechai contends that they are simply not enough. "The war against AIDS cannot be won through government efforts alone," he says. "AIDS is not a medical problem, it is a societal problem, and everyone must get involved."

One of Mr. Mechai's most successful efforts was gaining the co-operation of the military, whose Commander-in-Chief gladly donated three year's worth of free anti-AIDS spots during prime time television on the two army-controlled stations. He is also working through factories and schools, and carrying out day-long training sessions for representatives from big business, who go back to their companies armed with slide shows. "What we are telling them," says Mr. Mechai, "is that dead staff are bad staff and dead customers won't buy your products."

Despite the effectiveness of education, Mr. Mechai insists that a real war on AIDS must address root causes, which lie beneath the glittery surface of Bangkok's bars, and grow out of the poverty of Thailand's rural areas. According to Lim, a 23-year-old bar worker in one of Bangkok's seedier sex strips, most of her friends are less worried about AIDS than they are about getting enough to eat.

Whatever course the infection takes, Thailand will face sobering challenges in the years ahead, including medical care for those who will eventually fall prey to the full-blown disease. For immunologist Praphan Phanuphak, who sees AIDS patients as part of his daily work, government action should be more supportive of those who have already tested positive for HIV. "There must be adequate counselling," he says. "And we must also be ready with additional back-up measures, such as halfway homes and job training, to keep people from returning to the high-risk behaviour that gave them the disease in the first place."

Depressed by the growing number of carriers he sees, especially among youngsters and previously unrecognized high-risk groups, Dr. Praphan's view is that efforts at prevention have come too late. "We saw a problem in the gay community and we dealt with it," he says. "Then we tackled the intravenous drug-users. Now we are looking at female prostitutes, pregnant mothers and male heterosexuals. This is the wrong approach. Countries must jump several steps ahead of the actual situation—to protect those not yet infected." ■

Weaving the Cloth of a Better Life

By Ruth Massey

Mai Ha, Viet Nam — When Vi Thi Muon enters her house at noon after a morning working in the rice fields, it takes her eyes a few seconds to get accustomed to the dark interior. The first thing visible is the handloom standing near a small window at the far end of the long, spotless room.

The wooden walls are bare, except for several calendars with Vietnamese beauties and advertisements from American and French magazines. There is also a Tarzan cartoon. The only other objects are the carefully folded blankets in a neat pile on the floor. They have been woven on the loom by Mrs. Muon, a Muong hill-tribe woman who lives in the house with her husband, mother, two married daughters and their husbands and children.

The loom has long been central to the lives of the Muong and Tai hill-tribes who live in these remote mountains in Mai Chau Province, 400 kilometres northwest of Hanoi. In Viet Nam today, where most people have to have a second job to make ends meet, its importance is greater than ever. The extra income a woman earns from weaving can make the difference between her family going to bed hungry or having enough to eat. But when there is a bad harvest and there is no extra money to buy yarn, the looms stand silent, as happened after a disastrous drought in 1988. It was then that the Women's Union of Viet Nam asked the UN Development Fund for Women (UNIFEM) to help design a plan to loan the hilltribe women enough money to buy yarn when times were hard. A pilot group of 70 women from Mai Ha village were chosen because of the excellence of their weaving and the village's easy access by road to local markets. With UNIFEM providing US$183,000 in credit, a revolving loan fund was set up to purchase a steady supply of yarn, thus removing the weavers' main obstacle to regular production.

The first shipment of yarn arrived in Mai Ha in November 1989. "We started with 1,000 kilograms of natural and dyed cotton," says Nguyen Thi Dong, manager of the revolving fund. "The yarn was purchased in Hanoi because the quality was better and the price cheaper than what we find locally. With weavers paying back their loans from sales of blankets and mattress covers, we will be able to buy twice as much yarn next time."

The loan's time limit is six months, with half to be paid back within three months. Those who pay back half the

Hilltribe women were quick to recognize the profit potential of their improved looms.

UNDP photos by Ruth Massey

Most of the day is spent transplanting rice.

VIET NAM

A traditional design is woven by two sisters.

UNDP photo by Ruth Massey

loan on schedule can borrow again. "This acts as an incentive for weavers to become more productive," says Ms. Thi Dong. Although many weavers were hesitant about the loans at first — the hilltribes have no tradition of owing anyone anything — once the concept was thoroughly explained, most were eager to try. All 70 women in the pilot group repaid their debt well within the six-month period.

UNIFEM sent three weavers from Mai Ha to Vientiane, the capital of Lao PDR, where the Fund supports a successful textile handicrafts project that has been operating since 1983. In Vientiane, they learned how to work on wider, improved looms. On their return to Mai Ha they demonstrated their new skills to the others on wider prototype looms produced by local carpenters, who then adapted the old looms in weavers' houses. This has helped increase production of the plaid cloth for mattress covers and blanket linings in a wider, more marketable format.

"It used to take two weeks to weave a blanket. Now its off the loom and on a bed in less than a week," says Mrs. Muon, chewing on some betel nuts to restore her energy after her morning in the paddy transplanting rice. This afternoon, after spending one or two hours at her loom, she will be back in the rice field, bent at her task, her conical hat glinting in the sun. After dark she will come home to cook the evening meal with her daughters. Then she will again sit at her loom, working in the cool of the night by the light of a kerosene lamp.

But now her skill not only keeps her family warm. "In the past when I ran out of yarn, I had to stop weaving," she says as she sits at the loom on which lions in gold silk are taking shape on a background of bright red cotton, a traditional design used for blankets.

Tomorrow, Mrs. Muon will take her lion-studded blanket to the market at Keo Ko Wong, ten kilometres away, where she will find eager customers ready to pay $5 for it. In a country with a per capita income of $110 and where a kilo of rice costs 20 cents and a chicken 50 cents, her blanket will cover her family's basic needs for the next two months.

Mrs. Muon is not alone in recognizing the profit potential of her improved loom. The network of weavers trained on the new looms by the project has already been extended to 240 more women in four neighbouring villages. By the end of the year, it is hoped that weavers in all 21 villages of the province will have the ability to earn a steady income. ■

ENVIRONMENT

PHILIPPINES

Reviving Marine Resources

Philippine Fishermen and Scientists Join Forces

By David Kinley

Bolinao, Philippines — The sea has traditionally supplied the staples of life throughout much of the Philippines, a nation of over 7,100 islands. Nowhere is this more apparent than in the bustling beachside market here on the northwest coast of Luzon, where dozens of varieties of fresh and preserved seafood await sale beneath thatched canopies.

But such an abundance of seafood is increasingly rare now. Starting in the 1970s, fishermen across this far-flung archipelago began experiencing diminishing harvests. With incomes threatened, small children were hired by vessel operators to wade across the shoals and pound the reefs with metal rods, stampeding fish into waiting nets. In desperation, many small fishermen resorted to illegal blast fishing, using dynamite to stun their catch. Others dumped cyanide into the sea to capture colourful reef fish for living room aquariums overseas. The delicate coral reef was bleached and eventually died.

The cost of such marine ecological destruction has been steadily mounting across the Philippines. "Small-scale fishing is no longer viable on many stretches of this coastline because of overfishing, coastal pollution, sedimentation of the reefs and use of cyanide, illegal nets and dynamite," says Dr. Liana McManus, a marine biologist who directs the Marine Science Institute (MSI) in Bolinao. "One solution is for these small-scale fishermen to become seafarmers."

Fresh seafood is sold in the Bolinao market.

UNDP photos by David Kinley

Giant clams grown by the Marine Sciences Institute have high export potential.

"Seafarming" — the ecologically sound cultivation of all ocean resources — is proving a viable option for Virgilio Carolino and his neighbours in Lucero, a small fishing settlement of some 200 people about 15 minutes by speedboat from Bolinao. Mr. Carolino's earnings from the sea urchins he gathers on the flats near the shore have gone up dramatically in the past three years. He has abandoned his fish traps and his meagre trade in coconuts for a fulltime career in urchins. Ironically, Mr. Carolino attributes much of his recent success to "the ban" — a two-month annual prohibition on urchin harvesting imposed two years ago by Bolinao's town fathers at the urging of Dr. McManus' Institute.

"When Japanese buyers from Manila began offering good prices for urchin roe in the mid-1980s, people all along the coast began harvesting them feverishly," says Mr. Carolino. "Soon, both the harvest and the size of the urchins began diminishing. Month after month, our incomes were falling."

Fortunately, the mayor of Bolinao took action, requesting help from Dr. McManus and her colleagues at the MSI, a collaborative venture of the University of the Philippines and the United Nations Development Programme (UNDP). A rapid analysis by scientists at MSI determined that many of the urchins being caught were immature, and that heavy harvesting was taking place during the spawning season in December and January. The MSI staff proposed that the town council institute a complete ban on harvesting during the spawning months and a prohibition on marketing of immature urchins.

Making such a ban effective, however, required the education and co-operation of the entire community around Bolinao. "Our first move was to get the Municipal Council behind the concept of a ban," says Merito Miguel, Bolinao's mayor. "Then we had to show the community that we were really serious. I put a couple of my own relatives in jail for violations."

A fisherman builds a fish trap from local materials.

UNDP photos by David Kinley

Bolinao mayor Merito Miguel and seafarmer Virgilio Carolino helped push through the urchin ban.

To gain support of the communities dependent on urchin gathering, scientists at MSI put together a brief slide presentation explaining the biology of sea urchin and why it is critical to protect them during spawning. Then they took the slideshow on the road to Lucero and other villages to win their backing. "At first, most of the urchin gatherers opposed the ban," says Mr. Carolino. "But once we understood the reasons for it, we were willing to give it a try."

The two-month halt in harvesting proved enormously successful. Before the ban started in 1988, the average earning of a gatherer was a mere US$2.50 to $5 a day. In the two seasons since the prohibition, the average earnings have leaped to $25 to $50 a day — almost tenfold. Surveys by MSI scientists reveal that the local urchin population is higher than ever before.

Meanwhile, the marine specialists at MSI have been busily applying their expertise in pursuit of a much broader objective: community-based management of renewable coastal resources in the Lingayen Gulf, a 2,000 square-kilometre section of the South China Sea to the east of Bolinao. With support from the United States Agency for International Development and the Association of Southeast Asian Nations, MSI is now launching an "Integrated Coastal Management Plan" for the entire gulf. Working with the Department of Trade and Industry, the pilot plan will engage coastal communities directly in marine conservation and economic development activities and promote alternative livelihoods for poor fishermen. They are being trained in the seafarming of giant clams, oysters and seaweeds, production of peanuts and poultry, aquaculture and other small enterprises.

The lessons learned in working with the Municipal Council and urchin gatherers of Bolinao are being carefully applied elsewhere. "Coastal management has long been a top-down operation in the Philippines. Most often, it got stuck in the middle," explains Dr. McManus. "Now we are proving the value of working at the grass roots both in protecting the marine environment and benefitting the coastal people."

Almost a quarter million people live in the coastal areas of La Union and Pangasinan provinces bordering on the Lingayan Gulf. Tens of thousands of them still rely on uncontrolled fishing and gathering on the reefs. "The Lingayen Gulf represents a worst case scenario in coastal resource overuse," one recent analysis concluded. "The local population is both directly dependent on the area and responsible for its plight."

Armed with the country's first comprehensive plan for coastal resource management and the political support of local governments, MSI and its partners can begin to restore the ecological balance to this important section of Philippine coastline. If they do, indeed, succeed, they will be pioneering alternatives from which many other developing nations can benefit. ■

Dr. Liana McManus, Director of the MSI at Bolinao, holds a sea urchin.

Stop Blaming Africa for AIDS

It's Time Our Governments Fought Back

By Dr. Augustin Hatar

Kigali, Rwanda — Africa has been called many things: the hungry continent, the military dictatorship continent, the underdeveloped continent, the graft continent. Just when we were getting used to Africa's tarnished image, we have now been targeted in foreign media as the AIDS continent, the source of one of the most deadly viruses to attack mankind. While few people come out in the open to say this, the conclusion has been drawn that Africa is more culpable than any other region of the world.

This is an image Africa must fight, for up to now, there is no proof indicating Africa to be more AIDS prone than elsewhere. Formerly it did not matter if we were labelled this or that because it was Africans hurting Africans more than outsiders. Now, however, we are seen as the "poisoners" of the world. So far, over 150 nations have now reported cases of the disease and witch hunting for the source is only going to divert the struggle from what it truly is: a global phenomenon.

There is no doubt in my mind that AIDS is a big problem on the African continent, just as my personal experience has shown me that AIDS is a big problem in my country among some of my friends and acquaintances. Close friends of mine have died of the epidemic. I have known of families ravaged by the disease. Yet, I absolutely refuse to believe or accept that this disease is more of an African problem than elsewhere.

Each time I reflect about this disease I fall back on my stint in the United States when AIDS was first classified as a Haitian problem, then a homosexual problem, and when the disease continued to break the boundaries in which it was being defined, suddenly there was a whole continent to blame. Last year, for instance, a high ranking Tanzanian civil servant who went to Thailand on a trade mission was searched and interrogated at the airport. Airport officials suspected he was a carrier of AIDS. The reason: he came from an "infected" country.

Yes, there are many AIDS cases in Uganda, in Zaire, in Kenya, in Rwanda. There are equally many cases in the United States, in Switzerland, France, the Netherlands. The disease will as surely kill its Dutch host as it will kill the African one. Until a cure is found, all sufferers or carriers deserve to be seen first as basic human beings, not black or white or yellow.

Of course, the fact that the AIDS epidemic kills people, often at the height of their economic prowess, might make the African experience a little more frightening, considering that skilled personnel are scarce in many African countries. And yes, the sick and

UNDP photo by I. Rajeswary

Augustin Hatar.

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dying are going to overload African health services that are already generally weak — especially as governments continue to insist on free basic medical care for all, which of course is quite a positive thing.

But there is another side of the story that bears looking into: we may actually be better culturally equipped to handle the disease in the sense that a sick African is a community affair, and all members of that community are obliged to help look after that patient, and not abandon him or her to die under a bridge or on a windy street corner, which can happen in Manhattan.

This inability to understand the nature of the disease on the African continent has also led to problems in shaping strategies for containing it. Foreign experts have swarmed our continent armed with "Made-in-America" and "Made-in-Europe" posters, wall calendars, booklets, films and, of course, the condom.

These foreigners, who quite often do not speak the language of the people they are supposed to protect, have not even come from an anthropological background, which might have prepared them to understand better the societies they hope to reach. As a consequence they have not successfully broken through to the masses, whose understanding of diseases has virtually remained unchanged, and who therefore see no reason to change their social habits, especially regarding friendship and love.

In many African countries, we are going to have to sit down and carefully study the best ways to reach societies whose basic ways of seeing things are not written in any textbook. It is simply not enough to say that education holds the key, and that its nearest neighbour is the condom.

Meanwhile, as an African I feel uncomfortable knowing that I am going to be suspected of AIDS by virtue of being an African. I resent the accompanying rationalizations that Africans are promiscuous, and that is why they suffer so much from AIDS, particularly after what I have seen in Europe and America about the real value of the sexual act.

The worry as an African is this: where are our governments when we are being insulted as the AIDS continent? What do our embassies do when such stories come out? Come on Africa, you know you deserve better than this. ■

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